Jonathan P. Shapiro, MD PLLC

115 East 61st Street, New York, NY 10065

Today's Date _____/_____/_____ Your Primary Care Physician____________________________

Address:____ ________________________________Phone:________________

PATIENT INFORMATION

Patient's Last Name	First	Middle	❑ Mr. ❑ Miss ❑ Mrs. ❑ Ms.	Marital Status (Circle One) Single / Mar / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former Name)	Birth Date / /	Age	Sex ❑ M ❑ F

Street Address	Apt.#	Social Security #	Home Phone No. ( )

P.O. Box	City	State	ZIP Code

Occupation	Employer	Employer Phone No. ( )

Chose Clinic Because/Referred to Clinic by (Please check one box) ❑ Dr. ________________________________

Address: City State/Zip Phone

❑ Family ❑ Friend ❑ Close to Home/Work ❑ Yellow Pages ❑ Other ____________________

Other Family Members Seen Here ____

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Person Responsible for Bill	Birth Date / /	Address (if different)	Home Phone No. ( )
Is this person a patient here?	❑ Yes ❑ No		

Occupation	Employer	Employer Address	Employer Phone No. ( )

Is this claim covered under Worker's Compensation? ❑ Yes ❑ No

If Yes, Name of Comp carrier: ______________________________

Comp carrier address: ______________________________

Comp carrier phone #: ______________________________

Policy Holder Name: ______________________________

Carrier Case#: ____________________ WCB #: ______________

Date of Injury/Loss:__________________

Is this claim covered under a No Fault Auto Claim? ❑ Yes ❑ No

If Yes, Name of No Fault carrier: ______________________________

No Fault carrier address: ______________________________

No Fault carrier phone #: ______________________________

Policy Holder Name: ______________________________

Carrier Claim#: ____________________ Policy#: ______________

Date of Accident:__________________

Is this person covered under a Health Insurance Plan? ❑ Yes ❑ No Name of Primary Health Insurance Plan: __________________________

Subscriber's Name	Subscriber's S.S. #	Birth Date / /	Group #	Policy #	Co-Payment $

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other ____________________

Name of Secondary Insurance (if applicable)	Subscriber's Name	Group #	Policy #

Patient's Relationship to Subscriber ❑ Self ❑ Spouse ❑ Child ❑ Other ____________________

IN CASE OF EMERGENCY

Name of Local Friend or Relative (not living at same address)	Relationship to Patient	Home Phone No. ( )	Work Phone No. ( )

Turn Page Over

The above information is true to the best of my knowledge.

FINANCIAL ASSIGNMENT AND AGREEMENT:

1. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.**

2. **In Order To Control Your Cost of Billings, We Request That Your Charges For Office Visits Be Paid At The Conclusion Of Each Visit Unless You Are Covered By Medicare**

3. I request that payment of authorized Medicare and/or insurance benefits be made on my behalf to Jonathan P Shapiro MD for any services furnished me. I authorize any holder of medical information about me to release to the Health Care Financing Administration, its agents, or any insurance carrier I may have, any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance coverage is indicated in item 9 of the HCFA 1500 claim form or elsewhere on other approved claim forms or electronic submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare-assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and noncovered services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

4. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment

X ____

PATIENT/GUARDIAN SIGNATURE DATE

Please attach a copy of all insurance cards to this sheet